

APPENDIX A-2:

Data Abstraction Tool: Perioperative Antibiotic for Cesarean Section (MAT-2a,2b)

INSTRUCTIONS: Hospitals must refer to the appropriate version of data dictionary for abstraction guidelines that apply to this measure. Use of ***italic and underlined font*** throughout this tool indicates updated text has been inserted. The capital letters in parenthesis represents the field name that corresponds to the data element name.

1. Provider Name (PROVNAME) _____
2. Provider ID (PROVIDER-ID) _____ (AlphaNumeric)
3. First Name (FIRST-NAME) _____
4. Last Name (LAST-NAME) _____
5. Birthdate (BIRTHDATE) ____ - ____ - ____
6. Sex (SEX) ☐ Female ☐ Male ☐ Unknown
7. Postal Code What is the postal code of the patient's residence? (POSTAL-CODE) _____
Five or nine digits, HOMELESS, or Non-US
8. Race Code – (MHRACE) Select One Option
 - ☐ R1 American Indian or Alaska Native
 - ☐ R2 Asian
 - ☐ R3 Black/African American
 - ☐ R4 Native Hawaiian or other Pacific Islander
 - ☐ R5 White
 - ☐ R9 Other Race
 - ☐ UNKNOW Unknown/not specified
9. Ethnicity Code – (ETHNICODE) _____
(Alpha 6 characters, numeric is 5 numbers with – after 4th number)
10. Hispanic Indicator- (ETHNIC)
 - ☐ Yes
 - ☐ No
11. Hospital Bill Number (HOSPBILL#) _____
(Alpha/Numeric – field size up to 20)
12. Patient ID i.e. Medical Record Number (PATIENT-ID) _____ (Alpha/Numeric)
13. Admission Date (ADMIT-DATE) ____ - ____ - ____
14. Discharge Date (DISCHARGE-DATE) ____ - ____ - ____
15. Was the patient involved in a clinical trial during this hospital stay relevant to the measure set for this admission? (CLNCLTRIAL)
 - ☐ Yes (Review Ends)
 - ☐ No

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16. What was the patient's discharge disposition on the day of discharge? (DISCHARGDISP) (Select One Option)

- ☐ 01 = Home
- ☐ 02 = Hospice- Home
- ☐ 03 = Hospice- Health Care Facility
- ☐ 04 = Acute Care Facility
- ☐ 05 = Other Health Care Facility
- ☐ 06 = Expired
- ☐ 07 = Left Against Medical Advice / AMA
- ☐ 08 = Not Documented or Unable to Determine (UTD)

17. What is the patient's primary source of Medicaid payment for care provided? (PMTSRCE)

<input type="checkbox"/> 103	Medicaid (includes MassHealth)	<input type="checkbox"/> <u>282</u>	<u>BMC- MassHealth CarePlus</u>
<input type="checkbox"/> 104	Medicaid Managed Care – Primary Care Clinician (PCC) Plan	<input type="checkbox"/> <u>283</u>	<u>Fallon- MassHealth CarePlus</u>
<input type="checkbox"/> 108	MCD Managed Care - Fallon Community Health Plan	<input type="checkbox"/> <u>284</u>	<u>NHP- MassHealth CarePlus</u>
<input type="checkbox"/> 110	MCD Managed Care - Health New England	<input type="checkbox"/> <u>285</u>	<u>Network Health- MassHealth CarePlus</u>
<input type="checkbox"/> 113	MCD – Neighborhood Health Plan	<input type="checkbox"/> <u>286</u>	<u>Celticare- MassHealth CarePlus</u>
<input type="checkbox"/> 118	MCD Managed Care - Mass Behavioral Health Partnership Plan	<input type="checkbox"/> <u>287</u>	<u>MassHealth CarePlus</u>
<input type="checkbox"/> <u>207/274</u>	MCD Managed Care- Network Health (Cambridge Health Alliance)	<input type="checkbox"/> 119	Medicaid Managed Care Other
<input type="checkbox"/> 208	MCD Managed Care - HealthNet (Boston Medical Center)	<input type="checkbox"/> 178	Children's Medical Security Plan (CMSP)

18. What is the patient's MassHealth Member ID? (MHRIDNO) All alpha characters must be upper case

19. Does this case represent part of a sample? (SAMPLE)

- ☐ Yes
- ☐ No

20. Did the patient have a confirmed or suspected infection during this hospitalization prior to the c-section or were her membranes ruptured for \geq 18 hours? (CONFSUSPINFECT)

- ☐ Yes (Review Ends)
- ☐ No

21. Did the patient receive an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time? (PROPHYLAXCSECT)

- ☐ Yes (Review Ends)
- ☐ No

22. Were there any other procedures requiring general or spinal anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay? (OTHERSURG)

- ☐ Yes (Review Ends)
- ☐ No

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23. On what date did the Cesarean Section start? (CSECTDATE) ____-____-____
(MM-DD-YY or UTD)
24. At what time was the initial incision made for the Cesarean Section? (INITINCISIONTIME)
____:____ (military format – HH:MM or UTD)
25. Was an IV antibiotic administered to the mother in the perioperative period for Cesarean section surgical prophylaxis? (ABXCSECTION)
- ☐ Yes
 - ☐ No (Review Ends)
26. Which IV antibiotic was administered? (NAMEABX) (Select One Option)
- ☐ 1 - Ampicillin (go to question #28)
 - ☐ 2 - Cefazolin (go to question #28)
 - ☐ 3 - Gentamycin (go to question #28)
 - ☐ 4 - Other
27. Did the patient have any allergies, sensitivities, or intolerances to any of the recommended antibiotic classes for this measure? (ANTIALLERGY)
- ☐ Yes
 - ☐ No
28. On what date was the antibiotic administered? (DTABX)
____-____-____ (MM-DD-YY or UTD)
29. At what time was the antibiotic administered? (TMABX)
____:____ (military format – HH:MM or UTD)